RYAN WHITE NUTRITIONAL SUPPLEMENTS
Letter of Medical Necessity for Supplementation in ADULTS

Date: _____

As the primary medical caretaker for _____, who has a diagnosis of HIV/AIDS, it is my considered opinion that he/she requires enteric nutritional supplements.

I believe that nutritional supplements are medically indicated in this case and I have referred this patient for a professional Nutritional Assessment by a Registered Dietitian/Nutritionist.

I understand enteral nutrition must be evaluated by a Dietitian/Nutritionist every _____. *(Please indicate period of time for nutritional re-evaluation. Number of refills authorized cannot exceed this period of time.)*

Sincerely,

_____, M. D./ D.O./ ARNP/ PA-C
SIGNATURE
(Physician, Nurse Practitioner or Physician Assistant)

_____ _____
PRINT NAME Florida Medical License #
(Physician, Nurse Practitioner or Physician Assistant)

_____
PRINT NAME
(Registered Dietitian/Nutritionist)

_____ _____
SIGNATURE Dietitian/Nutritionist Florida License #
(Registered Dietitian/Nutritionist)

Nutrition Products Available Through Ryan White Title I

Physician/ Nurse Practitioner/ Physician Assistant/ Dietitian/Nutritionist, please indicate preferred product, flavor, number of servings recommended and number of refills authorized. *(Dietitian/Nutritionist, please refer to the Criteria for Dispensing Nutritional Supplements FORM for patient's nutritional assessment on back page.)*

Please document patient's: Height: _____ Weight: _____ ☐ Lbs ☐ Kgs IBW/UBW: _____ ☐ Lbs ☐ Kgs

NOTE: *1 Serving = 2 Scoops*

☐ Progain Powder - ___ No. of **SERVINGS per DAY** ☐ Vanilla ☐ Chocolate
(HIGH calorie product)
Number of Refills Authorized _____
(Number of refills authorized cannot exceed period of time for re-evaluation by nutritionist/dietitian as indicated above)

☐ IgG Pure - ___ No. of **SERVINGS per DAY** (Only natural flavor available)
(LOW calorie product)
Number of Refills Authorized _____
(Number of refills authorized cannot exceed period of time for re-evaluation by nutritionist/ dietitian as indicated above)

Please note: If the patient is on MEDICAID, please refer to the MEDICAID Medical Necessity Request Letter.
Patient's 10 digit MEDICAID Number: _____

Rev. 02/26/04

RYAN WHITE

CRITERIA FOR DISPENSING NUTRITIONAL SUPPLEMENTS

The following are potential situations where commercial nutritional supplements could be considered medically indicated.

Patient must meet at least two (2) criteria listed below.
(Consultation with a Registered Dietitian/Nutritionist for nutritional assessment and a Letter of Medical Necessity are required.)

Please check all that apply:

___ Current body weight < 10% IBW/UBW
___ Weight loss of:
- 5% of the initial/baseline weight over the past month -OR-
- 7.5% over the past 3 months -OR-
- 10% weight loss within the last 6 months

___ Body Cell Mass (BCM) < 40% (MALES) or BCM < 35% (FEMALE) of IBW
___ Body Mass Index (BMI) < 20
___ Recent illness/hospitalization that will interfere with patient's ability to consume or tolerate adequate non-supplemental nutrition
___ Diarrhea/malabsorption with > 3 large, liquid stools/day
___ Dysphagia and/or odonyphagia where commercial supplements are the only source of nutrition tolerated
___ Serum albumin < 3.5 g/dl
___ Failure to gain/maintain weight in the past when following a dietary regimen to promote weight gain
___ Inadequate living conditions or inability to buy/prepare meals
___ Inability to understand and or follow nutritional recommendations

NUTRITIONAL PLAN FOR SUPPLEMENTS

I. INITIAL Consultation: Date: _____ Weight: _____

Patient assessed/instructed by Registered Dietitian/Nutritionist: **(Please check the appropriate box)**

☐ Nutritional supplements **recommended** ☐ Nutritional supplements **NOT** recommended

II. FOLLOW-UP Visit: Date: _____ Weight: _____

Patient re-assessed for progress: **(Please check the appropriate box)**

☐ Nutritional supplements **continued** ☐ Nutritional supplements **discontinued**

III. ADDT'L FOLLOW-UP Visit: Date: _____ Weight: _____

Patient re-assessed for progress: **(Please check the appropriate box)**

☐ Nutritional supplements **continued** ☐ Nutritional supplements **discontinued**